Interactive Medical Systems

All claims must be in our office **5 working days** prior to your Scheduled check run

FSA Claim Form

EMPLOYEE PROFILE

COMPANY NAME _____

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____

MEDICAL FSA REIMBURSEMENT

Please indicate the amount of expenses you incurred since the last claim. Attach copies of receipts to this form and retain copies for your records.

	EXPENSE AMOUNT	DATES OF SERVICE
UNREIMBURSED MEDICAL, DENTAL, VISON, ETC.	$	FROM TO
	$	FROM TO

DAYCARE REIMBURSEMENT DCA

DEPENDENT CARE EXPENSES (under the age of 13)	EXPENSE AMOUNT	DATES OF SERVICE
	$	FROM TO
	$	FROM TO

By signing below, I certify that the total DEPENDENT DAY CARE expenses (if any) for which I am requesting reimbursement do not exceed the lesser of my or my spouses earned income for the plan year. I understand that reimbursed expenses cannot be claimed on my personal income tax return. Also, any unused funds in my account at the end of the plan year may be forfeited.

Dependent care IRS maximum salary reduction amount is $5,000 per year for married individuals filing joint returns and for single individuals, or a maximum of $2,500 for married individuals filing separate returns.

AUTHORIZATION

By my signature below, I certify that this information is correct, complete and meets all requirements for eligible health care and dependent care expenses

EMPLOYEE SIGNATURE _____ DATE _____

STATEMENT OF DAY CARE PROVIDER

I have provided day/adult care for:

DEPENDENT	AGE	EXPENSE AMOUNT	DATES OF SERVICE
			FROM TO
			FROM TO

PROVIDER NAME: _____ ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

PROVIDER SIGNATURE _____ DATE: _____ TAX ID (required): _____

CLAIMS ADDRESS

PO BOX 1349 WAKE FOREST, NC 27588
ATTN: CONSUMER ACCOUNTS DEPARTMENT
PHONE: 919-877-9933 EXT 5052 FAX:919-562-0021

FSA
Claim Form Instructions

HEALTH CARE ELIGIBLE EXPENSES

In general, an employee may be reimbursed for a health care expense which qualifies as a deduction on the federal income tax return, but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employee's income tax return. Some examples of eligible expenses are: deductible, coinsurance, dental, vision, hearing, and any eligible medical expense not covered under your health plan, i.e., routine care, prescription birth control. Dates of Service must occur within the requested plan year.

Employee contributions toward health premiums, disability, life and/or cancer coverage premiums, etc. have already been processed by your employer and do not need to be submitted and are not covered by your FSA.

HEALTH CARE SUPPORTING DOCUMENTATION

Eligible health care expenses not reimbursed by your health care plan will be reimbursed as long as you have the following documentation attached to this form. Medical expenses covered by your health care plan must be submitted to the insurance carrier before any remaining balance can be paid out of the health FSA account. ***You cannot pre-pay for healthcare services***. For all health care expenses, attach bills that clearly state the following:

- Name of participant(s) receiving the service
- Nature of service or supplies
- Expense Amount
- Name and address of provider of service
- Date service was rendered
- Explanation of Benefits (EOB) of any expenses that are partially covered by your medical insurance

DEPENDENT CARE ELIGIBLE EXPENSES

In general, the following rules apply to dependent care expenses:

- The expenses must be employment-related expenses for the care of a dependent of the employee who is under age 13 and entitled to a dependent deduction under Internal Revenue Service code section 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.
- If the services are provided by a dependent care center it must comply with all state and local laws and must provide care for more than six individuals (other than a resident of the facility).
- The payments cannot be made to a person who is claimed as a dependent by the employee. The annual amount submitted for reimbursement cannot exceed the earned income of the lower paid spouse.
- Day care expenses should not be submitted more often than monthly.

DAYCARE SUPPORTING DOCUMENTATION

The following supporting documentation must be submitted for dependent day care reimbursement:

- Dependent Name/Relationship
- Date(s) of Service (within the plan year)
- Expense Amount
- Providers Name Address/Phone Number
- Tax ID Number
- Providers Signature
- Age of Child